TCT-221

Coronary Chronic Total Occlusions and Elderly: Clinical Profile And Prognosis

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Background: Coronary chronic total occlusions (CTO) are a common finding among patients with known coronary disease. There are few data about elderly with CTO(>75 year old). The aim our study was analyze what factors can determine the decision making treatment and prognosis on this population.
Methods: Monocentre registry of consecutive CTO patients >75 years. We analyzed clinical and angiographic characteristics and several risk scores. We compare this population with the global population of CTO
Results: Between June 2010-December 2012, 711 consecutive patients were included in our registry. 174 >75 years (medium age 80.3 ±3.2 y) In the elderly group we found a higher rate of women (24.7 vs 10.7% p< 0.001) hypertension (77.6 vs 68.3%, p= 0.019), higher ACEF score (2.07 vs 1.62, p< 0.001), Syntax creatinine score (58.6 vs.39.9, p< 0.001) Syntax logistic score (17.8 vs 12.4, p< 0.001) and Global Syntax score (77.5 % vs 42.5%, p=0.001). The treatment choice was left to the cardiologist's criterion. 29 patients were referred to percutaneous revascularization (PCI), 21 to surgery (CABG) and 124 to medical therapy. The tree groups were similar in all factors analyzed but patients managed by medical therapy were older (80.9±3.2 vs 78.4±2.2 PCI vs 79.2±2.4 CABG; p< 0.001). Revascularization was less frequent in elderly (CABG (12.1% vs 26.6% p< 0.001) and PCI (16.7 % vs 32.2% p< 0.001)). We made a clinical or telephone follow-up (1.9 ± 0.9 years). Elderly have a worse prognosis: higher incidence of acute myocardial infarction (AMI) (12.6 vs 4.5%, p< 0.001), cardiovascular death (CVD)(20.7 vs 4.5%, p< 0.001) and all causes of death (ACD)(21.8 vs 8.4% p< 0.001). Patients sent to CABG had the best prognosis independently of their age. Prognosis in patients sent to PCI was intermediate between CABG and medical therapy no mater their age. Elderly referred to medical therapy had the worst prognosis: highest rates of AMI (P< 0.001), ACD and CVD (P< 0.001)
Conclusions: Most of elderly CTO patients were managed by medical treatment. This decision had serious prognostic implications, higher rate of AMI and cardiovascular death. The prognosis of patients sent to revascularization (CABG or PCI) was independent on their age

Coronary Lesions - Left Main

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Outcomes of Medical Treatment for Unprotected Left Main Coronary Artery Stenosis

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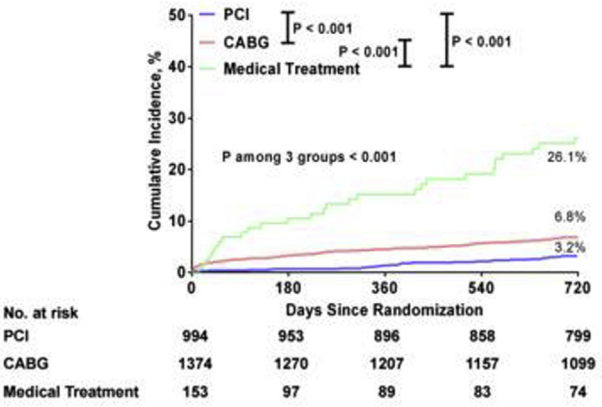
Background: There is a lack of data regarding the outcomes of medical treatment for stable coronary artery disease (SCAD) involving unprotected left main coronary artery (ULMCA) stenosis.
Methods: From March 1992 to February 2011, among 3,041 patients enrolled in ASAN MAIN registry, 411 patients did not receive the revascularization for ULMCA stenosis. Among those, 122 patients had severe co-morbidities and 134 patients had intermediate stenosis. Remaining 153 patients were identified as "*amenable but declined*" for the revascularization (medical treatment group) and compared with those receiving percutaneous coronary intervention or coronary artery bypass grafting. Primary endpoint was death from any causes.
Results: The crude 2-year rates of death from any cause (PCI, 3.2%; CABG, 6.8%; medical treatment, 26.1%; p< 0.001) and the composite of death, myocardial infarction, or stroke (PCI, 5.0%; CABG, 8.3%; medical treatment, 27.0%; P < 0.001) were significantly higher in medical treatment group. Multivariate Cox's proportional hazards model revealed that medical treatment was an independent predictor of death (HR, 0.164; 95% CI, 0.087 – 0.310; p value < 0.001, compared with PCI; HR, 0.285; 95% CI, 0.169 – 0.481; p value < 0.001, compared with CABG) and the composite of death, MI, or stroke (HR, 0.271; 95% CI, 0.134 – 0.550; p value < 0.001, compared with PCI; HR, 0.448; 95% CI, 0.246 – 0.817; p value = 0.009, compared with CABG).
Conclusions: Although clinical presentation was stable, non revascularized ULMCA stenosis was associated with the higher mortality.



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Clinical Outcome of Left Main Stenting With or Without Aorto-Ostial Coverage: Data from ASAN-MAIN Registry

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Background: The aim of this study was to compare the clinical outcomes of unprotected left main coronary artery (ULMCA) stenting with or without aorto-ostial coverage.
Methods: From ASAN-MAIN registry, a total of 550 with ULMCA stenosis without significant aorto-ostial stenosis (angiographic diameter stenosis>50%) who were treated by drug-eluting stent between March 2003 and June 2010 and were categorized into stenting with aortic-ostial coverage (AOC, N=316) versus stenting without aorto-ostial coverage (No-AOC, N=234).
Results: During 2-year follow-up, all-cause mortality (4.7% in No AOC group vs. 2.8% in AOC group, P=0.24), myocardial infarction (1.7% in No AOC group vs. 0.95% in AOC group, P=0.42), target lesion revascularization (3.0% in No AOC group vs. 0.63% in AOC group, P=0.81) were not significantly different. Among 407 patients with angiographic follow-up, LM in-stent restenosis did not differ between groups (4.3 % in No AOC group vs. 5.1 % in AOC group; p=0.66). For aorto-ostial lesion, in-stent restenosis occurred 1 patients (0.32 %) in AOC group and de novo ostial stenosis occurred 4 patients (1.71 %) in No AOC group (P=0.316). After Cox regression multivariable analysis, AOC did not affect the death (HR 0.59, 95% CI 0.24-1.43; p= 0.25), the composite of death, MI, target lesion revascularization (HR 1.02, 95% CI 0.59-1.77; p= 0.94).